DETAINEE MEDICAL OPERATIONS DURING OPERATION IRAQI FREEDOM: DETERMINATION OF A TRANSITION PLAN

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14. ABSTRACT The United States Armed Forces in Iraq currently provides healthcare for thousands of detainees in U.S. custody. Required healthcare, in accordance with Department of Defense Directive and U.S. Army regulation, for detainees surpasses current deployable U.S. Army medical capabilities. Planning for the Iraqi government to take over essential services must include the provision for detainee healthcare. Nearly eight years prior to the initiation of Operation Iraqi Freedom, a decay of the Iraqi healthcare system began. Toward the end of the Saddam Hussein regime, money was shifted away from the healthcare system to bolster the military capability. Currently, a lack of security has effected reconstruction projects and resulted in hundreds of doctors and nurses to flee the country for personal safety as they are routinely kidnapped and killed by insurgent forces. This study answers the question: In light of international guidelines, Iraqi capabilities and U.S. obligations, can a transition plan be developed to allow the Iraqi government to assume the medical operations for detention operations? The study leads to the conclusion that U.S. Army regulations and doctrine does not fully support the Department of Defense Detainee Operations Policy. Additionally, new classifications of detained persons by U.S. Government have added confusion as to the treatment required and placed restraints for disposition of detainees on U.S. Army units conducting detention operations. Finally, the lack of security has dramatically slowed reconstruction projects, including hospitals and clinics; along with the inability of the Iraqi Government to maintain proper checks and balances among ministries, has permitted a continual decline of the medical capabilities throughout the country. Removal of discrepancies throughout the Department of Defense's detainee operations policy, acceptance of the Iraqi standard of detention healthcare and continue to support the Iraqi government in reducing sectarian violence are key elements in order to facilitate a detainee medical operation transition plan.

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The opinions and conclusions expressed herein are those of the student author and do not necessarily represent the views of the U.S. Army Command and General Staff College or any other governmental agency. (References to this study should include the foregoing statement.)

ABSTRACT

DETAINEE MEDICAL OPERATIONS DURING OPERATION IRAQI FREEDOM: DETERMINATION OF A TRANSITION PLAN, by MAJ Matthew A. Sheaffer, 75 pages.

The United States Armed Forces in Iraq currently provides healthcare for thousands of detainees in U.S. custody. Required healthcare, in accordance with Department of Defense Directive and U.S. Army regulation, for detainees surpasses current deployable U.S. Army medical capabilities. Planning for the Iraqi government to take over essential services must include the provision for detainee healthcare. Nearly eight years prior to the initiation of Operation Iraqi Freedom, a decay of the Iraqi healthcare system began. Toward the end of the Saddam Hussein regime, money was shifted away from the healthcare system to bolster the military capability. Currently, a lack of security has effected reconstruction projects and resulted in hundreds of doctors and nurses to flee the country for personal safety as they are routinely kidnapped and killed by insurgent forces.

This study answers the question: In light of international guidelines, Iraqi capabilities and U.S. obligations, can a transition plan be developed to allow the Iraqi government to assume the medical operations for detention operations? The study leads to the conclusion that U.S. Army regulations and doctrine does not fully support the Department of Defense Detainee Operations Policy. Additionally, new classifications of detained persons by U.S. Government have added confusion as to the treatment required and placed restraints for disposition of detainees on U.S. Army units conducting detention operations. Finally, the lack of security has dramatically slowed reconstruction projects, including hospitals and clinics; along with the inability of the Iraqi Government to maintain proper checks and balances among ministries, has permitted a continual decline of the medical capabilities throughout the country. Removal of discrepancies throughout the Department of Defense's detainee operations policy, acceptance of the Iraqi standard of detention healthcare and continue to support the Iraqi government in reducing sectarian violence are key elements in order to facilitate a detainee medical operation transition plan.

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ACRONYMS

AFMIC	Armed Forces Medical Intelligence Center
AMEDD	Army Medical Department
AR	Army Regulation
ATLS	Advanced Trauma Life Support
BIF	Brigade Internment Facility
CDCC	Central Detainee Collection Camp
CI	Civilian Internee
CINCFE	Commander in Chief, Far East
COMUSMACV	Commander, United States Military Assistance Command Vietnam
CSH	Combat Support Hospital
DAIG	Department of the Army Inspector General
DIF	Division Internment Facility
DOD	Department of Defense
DODD	Department of Defense Directive
DODI	Department of Defense Instruction
DOJ	Department of Justice
EPW	Enemy Prisoner of War
FH	Field Hospital
FM	Field Manual
FOB	Forward Operating Base
GC	Geneva Convention Relative to the Protection of Civilian Persons in Time of War
GPW	Geneva Convention Relative to the Treatment of Prisoners of War

GWOT	Global War on Terror
GWS	Geneva Convention for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field
GWS Sea	Geneva Convention for the Amelioration of the Condition of Wounded, Sick, and Shipwrecked Members of the Armed Forces at Sea
JCS	Joint Chiefs of Staff
JP	Joint Publication
KSA	Kingdom of Saudi Arabia
ICRC	International Committee of Red Cross
MACV	Military Assistance Command Vietnam
MMC	Mixed Medical Commission
MNF-I	Multinational Force – Iraq
MOD	Ministry of Defense
MOH	Ministry of Health
MOI	Ministry of Interior
OD	Other Detainee
OEF	Operation Enduring Freedom
OIF	Operation Iraqi Freedom
POW/PW	Prisoner of War
RP	Retained Person
R&R	Rest and Relaxation
TIF	Theater Internment Facility
TOE	Table of Organization and Equipment
TF	Task Force
UN	United Nations

UNAMI	United Nations Assistance Mission for Iraq
UNC	United Nations Command
USAID	United States Agency for International Development
VA	Department of Veterans Affairs
VC	Viet Cong

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CHAPTER 1

INTRODUCTION

Introduction and Background

The purpose of this study is to examine current requirements for conducting healthcare for detained persons by United States (U.S.) armed forces involved in Operation Iraqi Freedom (OIF) and explore the challenges associated in developing a comprehensive plan to transition detention operations to indigenous Iraqi forces.

Multinational Forces-Iraq (MNF-I) has the mission to assist the Iraqi people to establish a functional government, revitalize the infrastructure and develop operating social systems. Within the organizational structure of MNF-I, Task Force (TF) 134 is the element responsible for detention operations conducted by U.S. armed forces and for developing a plan to transition detention operations to the Iraqi government. The transition plan concept covers all aspects of detention operations including training and equipping the detention facility staff to provide essential commodities, as well as medical treatment, for detained persons. The basis for the transition plan is current U.S. Army organizational structures and operating parameters used by U.S. Army units conducting detention operations in Iraq. A primary focus of TF 134 is developing and executing a transition of detention operations from U.S. armed forces to representatives of the Iraqi government. Determining the status of a detainee is the first question that must be answered to determine level of required medical care.

Determination of a person's categorization brought to a detention facility is required to determine level of care and security is required. This seemingly simple task is quite complex. Major reasons for the complexity are the contradictory and unclear

directives, guidance and laws of categorizing a person as a detainee. A common reference to wartime human rights and humanitarian principles are the 1949 Geneva Conventions and Protocols of 1977. Notably, Convention number I, Convention for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field and Geneva Convention Relative to the Treatment of Prisoners of War (GWS), contain several articles that address the categorization and treatment of prisoners of war (The Avalon Project). Article 4 of GWS, explicitly defines the criteria that must be met for a person to be entitled to prisoner of war status. A prisoner of war, according to the convention, is a person who falls into the power of the enemy and meets one of the following criteria: is a member of the opposing armed forces; a member of other militias or other volunteer corps; a member of regular armed forces that profess allegiance to a government or an authority not recognized by the detaining power; an inhabitant of a non-occupied territory who spontaneously take up arms to resist the invading force; or a person who accompanies the armed forces, such as correspondent or contractors (The Avalon Project).

Article 5 of GWS states the following cautionary rule:

> Should any doubt arise as to whether persons, having committed a belligerent act and having fallen into the hands of the enemy, belong to any of the categories enumerated in Article 4, such persons shall enjoy the protection of the present Convention until such time as their status has been determined by a competent tribunal. (The Avalon Project)

According to the International Committee of the Red Cross, the U.S. is a signatory of these international agreements. However, a signature does not bind a nation to the treaty unless the document has also been ratified by that nation. The US Congress ratified and the President of the United States has signed all the Geneva Conventions with

the exception of the two protocols of 1977 (International Committee of Red Cross). This became the center of the arguments surrounding the decisions made by the U.S. government, after 11 September 2001, regarding whether the Geneva Conventions applied to al-Qaeda or the Taliban militia.

During the preparation for actions against al-Qaeda, the Bush administration was reluctant to accept that the Geneva Convention relative to the Treatment of Prisoners of War would apply to al-Qaeda detainees. In January, 2002, the U.S. Department of Justice (DOJ) concluded in a memorandum to the Department of Defense that the obligations contained within the Geneva Conventions did not apply since al-Qaeda, a non-state actor, was not a national signatory to international conventions and treaties. Additionally, the DOJ concluded that the treaties did not apply to the Taliban militia (Office of the Deputy Assistant Attorney General, 2002). Then on 7 February 2002, President Bush issued a memorandum stating his acceptance of the legal conclusion of the DOJ and determined that none of the provisions of the Geneva Conventions applied to the U.S.'s conflict with al-Qaeda in Afghanistan or other locations throughout the world because al-Qaeda is not a state and not a signatory of the treaty. President Bush continued his memorandum by stating, "as a matter of policy, the United States Armed Forces shall continue to treat detainees humanely and, to the extent appropriate and consistent with military necessity, in a manner consistent with the principles of Geneva" and reaffirmed the order issued by the Secretary of Defense for the U.S. Armed Forces to treat detainees humanely and consistent with applicable law (Office of the President of the United States). On 10 April 2002, The Assistant Secretary of Defense, Dr. William Winkenwerder, reinforced President Bush's legal conclusion through a memorandum specifically stating "detainees

under U.S. control suffering from a serious disease or condition that necessitates special treatment, surgery, hospital care or rehabilitation shall be provided, to the extent feasible, the medical attention required by their state of health" (Office of the Assistant Secretary of Defense). The United States Army Medical Command issued their interim guidance on detainee medical care with an overall theme that "detainees should receive medical care equal to that of our own troops" (Headquarters, United States Army Medical Command, 2005). This is the basis from which military personnel operating throughout Iraq operate from.

In July 2004, the Department of the Army Inspector General (DAIG) found shortcomings with the medical treatment of detainees. They referenced a message written from the Chairman, Joint Chiefs of Staff dated 27 January 2002, that reiterated President Bush's comment that Taliban militia and al Qaeda under control of U.S. armed forces control would be treated humanely and to the extent appropriate and consistent with military necessity, in a manner consistent with the principles of the Geneva Conventions of 1949 (Department of the Army Inspector General 2004, 68). The DAIG stated that the provisions of the Geneva Conventions are the benchmark with which to measure whether treatment provided by U.S. armed forces to detainees is conducted humanely (Department of the Army Inspector General 2004, E-85). Within the DAIG's report, specific reference was made to Army Regulation (AR) 190-8, Enemy Prisoners of War, Retained Personnel, Civilian Internees and Other Detainees, 1 October 1997. AR 190-8 clearly states "dental, surgical, and medical treatment will be furnished free to the CI" (AR 190-8 1997, 22). This of course begs the question of the necessity of categorizing detained persons and what level of care does a detainee receive when not in a specified

category. The DAIG reported that of the medical personnel interviewed, they did not receive specific detainee training and were not aware of AR 190-8, but most believed that detainees were to receive the same level of care as that provided to Coalition Forces (Department of the Army Inspector General 2004, 69).

To the healthcare provider operating inside a U.S. medical treatment facility, classification of injured personnel had no significant relevance at the time of initial treatment. As an injured person was brought to the Army Combat Support Hospital (CSH) located at one of the Theater Internment Facilities (TIF), the medical staff would perform the necessary actions that were in the best interest of the patient. For reasons of precautionary safety procedures, classification of a patient was needed as soon as possible. Classification of any injured was needed to determine if patient restraints were needed. Inside the medical treatment facility, military police were stationed at various locations to provide security for the medical staff.

As the U.S. continues to work with the Iraqi government to assume more responsibility for revitalizing the infrastructure and operating social systems, the healthcare system in Iraq has made progress but there is a lot of work to be done. Prior to United Nations (UN) imposed sanction in 1990, Iraq had one of the most robust and efficient healthcare systems in the Middle East. Under the Saddam Hussein regime, the healthcare budget was dramatically reduced during the years following Operation Desert Storm, 1990 causing the healthcare system began to decay (Aziz 2003, 1288). The current Minister of Health, Dr. Khodeir Abbas, is optimistic about the progress made within the healthcare system. In an interview conducted December 31, 2003, Dr. Abbas claimed that an extensive immunization program reached more than 70% of Iraq and

health education programs have been initiated (News Hour, 2003). Despite the progress made, an estimated 17,000 doctors and an unknown number of healthcare workers have led in fear of their lives. Nellie Bristol, a writer for *The Lancet*, claims in May, 2006 eight doctors and eight nurses were killed along with 42 doctors and seven nurses wounded. Estimates indicate as many as 250 Iraqi doctors have been kidnapped in the past two years (Bristol 2006, 905). According to Bristol, overcoming the shortage of doctors and nurses could take up to 10 years (Bristol 2006, 906).

Primary and Secondary Questions

This study will answer the question; in light of international guidelines, Iraqi capabilities and U.S. regulatory obligations, can a transition plan be developed to allow the Iraqi government to assume the medical operations for detention operations from U.S. armed forces? Specifically, this study will examine current U.S. law, international law, law of war, treaties, conventions and U.S. Army regulations and doctrine governing healthcare for detainees and analyze the current and proposed Iraqi healthcare revitalization plan based on the requirements established by these laws and regulations. To answer the primary question sufficiently, secondary questions are developed to facilitate answering the primary question. First, what is the current U.S. policy or doctrine pertaining to detention healthcare operations? An understanding of current U.S. law, policy, regulation and doctrine will determine the medical care obligations of U.S. armed forces conducting detention operations. Additionally, a thorough review and understanding of laws, policy, regulations and doctrine will determine whether or not there are any discrepancies between the established requirements and the provided level of care. Second, what is the required level of medical care for detainees? Defining the

level of care establishes the requirement from which a determination of what type of capability is needed to achieve the requirement. Third, are there international standards for detainee healthcare? Examining current international standards will identify possible requirements for the indigenous Iraqi forces to assume detention medical operations. Fourth, what governing body is responsible for establishing and maintaining international detention standards? Identifying what agency or agencies are responsible for establishing and maintaining existing international standards will allow the researcher a greater depth and breadth in determining transition plan requirements. Fifth, can the Iraqi healthcare system absorb the detention healthcare mission? Analyzing the capabilities of the Iraqi healthcare system will assist the researcher to identify possible shortfalls that would preclude transition of detainee medical healthcare. Sixth, what is the Iraqi Ministry of Health's plan to revitalize the public healthcare system? Examining the goals, objectives and priorities of the Ministry of Health's healthcare revitalization plan will provide a proposed time frame in which the goals are scheduled to reach completion.

Significance of Research

This study was designed to analyze international guidelines, Iraqi capabilities and U.S. obligations to determine whether a transition plan can be developed to allow indigenous Iraqi forces to assume the detention medical operations throughout Iraq. The study will determine whether or not current international guidelines, Iraqi capabilities and U.S. obligations allow for a feasible and legal transition plan to be developed. The study will explore possible solutions to the difficulties identified to allow for the successful transition of detention healthcare operations to indigenous Iraqi forces.

Limitations

Detainee operations are very complex and this thesis will not answer all the questions. There are several limitations beyond the control of the researcher. First the researcher is not a legal expert and will avoid a detailed and technical analysis of the Geneva Convention and U.S. law. Secondly, this research is limited by time. The researcher is simultaneously completing resident Command and General Staff College while this study is being conducted. Therefore, this study does not include interviews or surveys. This result is a limitation of research to Department of Defense Directives, Department of Defense Instruction, U.S. Army Regulations, U.S. Army doctrine, personnel observation, published reports, articles, and Internet searches. This research limitation results in only unclassified material used in this study. This study relies on information from ongoing actions in OIF, the researcher is limited by the availability of an access to published material. Additionally, this study is limited to laws, policies, directives and regulations impacting the U.S. Army. Concurrent planning or activities by other U.S. or international agencies pertaining to detention healthcare operations is not included.

Delimitations

This research and recommendations are not intended as a policy letter or as interim guidance. Also, this research does not discuss the repatriation process, alleged or documented abuse cases or medical care provider role in the interrogation process.

Assumptions

1. The U.S. Forces will continue to conduct Operation Iraqi Freedom over the next 6 years.

2. U.S. forces will continue to hold detainees while conducting OIF.

3. U.S. Forces will continue to operate under the premise of "treat all injuries in accordance with severity."

4. Insurgent forces will continue to threaten, kidnap or kill Iraqi healthcare professionals.

5. A new Minister of Health (MoH) will assume office with each election.

6. The U.S. will not change the classification of detainees, al Qaeda or other terrorist organizations while executing Global War on Terror operations.

7. The U.S. will not change their position on the level of treatment provided to detainees.

8. Iraq will be able to avoid a major endemic breakout.

Summary and Conclusion

This study is timely and relevant and will provide not only solutions to the current situation in Iraq, but is also useful to an enduring and sensitive mission of detention operations conducted faced by U.S. armed forces today and most likely, in the future.

The next chapter, "Review of Literature," is a review of the current literature on formation, significance, and application of Law of War. The chapter will also delve into U.S. use of Law of War, apply recent examples and explore recent doctrinal and regulatory changes. Additionally, the chapter will provide a historical perspective of detainees and detention facilities, including healthcare workload. Finally the chapter will

examine current and projected status of the Iraqi healthcare system and detention facility operations.

CHAPTER 2

LITERATURE REVIEW

Introduction

The purpose of this study is to examine current requirements for conducting healthcare for detained persons by United States (U.S.) armed forces involved in Operation Iraqi Freedom (OIF) and explore the challenges associated in developing a plan to transition detainee medical operations to indigenous Iraqi forces.

The reason for this chapter is to review and analyze literature on rules, regulations, policies, laws and doctrine pertaining to detainees, detention operations, the Iraqi healthcare system and how the information relates to the primary question of in light of international guidelines, Iraqi capabilities and U.S. regulatory obligations, can a transition plan be developed to allow the Iraqi government to assume the medical operations for detention operations from U.S. armed forces. This chapter is comprised of four sections: law of war, U.S. application of law of war, a historical perspective of detainees and detention facilities and the revitalization process of Iraq's healthcare system since the initiation of Operation Iraqi Freedom (OIF). The law of war section examines the formation, significance and application of law of war primarily by U.S. armed forces and examines how other States and non-State organizations are influenced and apply the law of war. Recent historical events provide examples how the U.S. interpreted and applied the Law of War to detained persons and the international impact. This section also provides information pertaining to regulatory and doctrinal changes within the Department of Defense relating to captured personnel and detention facility operations from the Korean War to present day. The historical perspective of detainees

and detention facilities will examine how detainees have been treated by U.S. forces in past conflicts. The final section will examine the current status of the Iraqi healthcare system and plans to revitalize the healthcare system as determined by Iraq's Ministry of Health.

Before delving in to how and where current policies and laws regarding detained persons originated, understanding the basic principals of the law of war will provide a foundation for the remainder of the chapter. The first component is *Jus ad Bellum*, which serves to prevent war. *Jus ad Bellum* deals conflict management and how armed conflict is initiated. *Jus in Bello* attempts to regulate actions of the parties after hostilities are initiated and what legal and moral restraints apply (Puls 2005, 6). For the purpose of this study, *Jus in Bello* is the primary focus as the researcher will not attempt to justify or reason why States engage in conflict. These two concepts provide the foundation on which contemporary law of war was built.

Since man's existence, the use of force has been used to defeat an opposing force or deter aggression. The use of force has also been regulated through traditions, obligations, treaties, conventions or necessity. The origins of contemporary law, *Jus ad Bellum*, are commonly attributed to Roman law. Many historians credit Saint Augustine's Just War doctrine as an important milestone in the development of contemporary rules regulating the use of force and the conduct of war. St. Augustine reasoned that achieving peace could be a just cause of war for Christians. His Just War doctrine permitted Christians to protect themselves against bandits but also sanctioned the use of force against a wide variety of provocations (O'Connel, 106). The Just War doctrine generated a widely recognized set of principles that war could only be decided by a legitimate

authority, war must be made in the advancement of good, other than self defense there must be a reasonable prospect of victory, every effort must be made to resolve difference through peaceful means, the use of force must be proportionate to the objective, and the innocent will remain immune from the attack (Puls 2005, 9). These principles represented the early customary law of war.

During the American Civil War, Francis Lieber wrote the Instructions for the Government of Armies of the United States in the Field. This document is commonly referred to as General Orders No. 100 or the Lieber Code. The Lieber Code was a detailed manual for the use of the Union forces to guide their actions on the battlefield. Francis Lieber was a German-American professor of international Law at the Columbia College and had fought in conflicts across Europe prior to immigrating to America. Francis Lieber had lost a son fighting for the confederacy and had two sons who fought for the Union. Because of his unique qualifications, the Lieber Code was widely accepted by many of the leading western powers and adopted the code for their militaries (O'Connel, 106).

The Lieber Code consists of 157 articles, three of which are noteworthy within the context of this study.

Article XLIX

> A prisoner of war is a public enemy armed or attached to the hostile army for active aid, who has fallen into the hands of the captor, either fighting or wounded, on the field or in the hospital, by individual surrender, or by capitulation.

Article LVI

> A prisoner of war is subject to no punishment for being a public enemy, nor is any revenge wreaked upon him by international infliction of any suffering, or disgrace, by cruel imprisonment, want food, by mutilation, death, or any other barbarity.

Article LIX

> A prisoner of war remains answerable for his crimes committed against the captor's army or people, committed before he was captured, and for which he has not been punished by his own authorities. All prisoners of war are liable to the infliction of retaliatory measures. (The Avalon Project, 1996)

The Lieber Code, while establishing rules of conduct for Union forces, established categories for personnel on the battlefield.

Three years prior to the Lieber Code being published, a gentleman by the name of Henri Dunant witnessed an event that changed his life forever. Henri Dunant observed the suffering of wounded soldiers after the Battle of Solferino in 1859, but what left a lasting impression were the unselfish acts of Italian nurses and doctors rendering care to the wounded, regardless of nationality, inside a nearby church. Henri Dunant asked one of the nurses why she was providing care to the wounded soldiers, she responded with "tutti fratelli," "they are all our brothers." Henri Dunant remained intrigued by the unselfish acts he witnessed at *Chiesa Maggiore* (Koch 2005, 249). In 1862, Dunant published *A Memory of Solferino* that described the battle that ensued and the unselfish care of the wounded. At the end of his work, Dunant posed a question: "Would it not be possible, in time of peace and quiet, to form relief societies for the purpose of giving care to the wounded in wartime by zealous, devoted and thoroughly qualified volunteers (International Committee of the Red Cross, 2004)?" This question led to the founding of the Red Cross. Dunant then made a request to European military authorities if they would generate "some international principle, sanctioned by a convention and inviolate in character, which, once agreed upon and ratified, might constitute the basis for societies for the relief of the wounded in the different European countries?" The response from European military authorities served as the basis for the development of the Geneva

Convention for the Amelioration of the Condition of the Wounded in the Armies in the Field (International Committee of the Red Cross, 2004).

On 6 June 1864, the Swiss government, who agreed to host the convention, sent invitations to all European governments, the United States of America, Brazil and Mexico. Sixteen States sent representation to the conference that met from 8 to 28 August 1864 to discuss a draft convention prepared by the International Committee (International Committee of the Red Cross, 2004).

The foundation of what would become modern humanitarian law became effective on 22 August 1864 when the Geneva Convention for the Amelioration of the Condition of the Wounded in Armies in the Field was signed. Ten nations ratified the convention by the end of the year. Delegates from the International Committee of the Red Cross (ICRC) remained diligent in developing international humanitarian law during the Franco-Prussian War. The ICRC formed the first Information Agency designed to inform families of condition and location of wounded or captured soldiers to families. Through the years, the Geneva Conventions were revised as a result of new weapons and new types of conflict. Due to deplorable conditions, abuses, longevity of capture and unwillingness of warring parties to repatriate severely wounded and sick prisoners during World War I, a second convention relating to the treatment of prisoners of war was introduced in 1929. At the end of World War II, inefficiency of the current conventions was evident. Working in postwar Europe, the ICRC was working to assist three categories of people: displaced persons attempting to reunite with families and return home; thousands of interned or recently liberated German prisoners of war requiring healthcare; and those suffering from the effects of war. The suffering of millions of

people after WWI spurred many people and organizations, especially the ICRC, to revise and redraft humanitarian law. In the spring and summer of 1949, another convention convened in Geneva. The results, the four conventions approved by the ICRC and ratified by the U.S. Senate on 2 February 1956 (Gebhardt 2005, 13).

The collection of the four 1949 conventions is commonly referred to as the Geneva Conventions for the Protection of War Victims of 12 August 1949. These four conventions are titled and abbreviated as follows: Geneva Convention for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field (GWS); Geneva Convention for the Amelioration of the Condition of Wounded, Sick, and Shipwrecked Members of the Armed Forces at Sea (GWS Sea); Geneva Convention Relative to the Treatment of Prisoners of War (GPW); and Geneva Convention Relative to the Protection of Civilian Persons in Time of War (GC).

Since this study is primarily concerned with GPW and its application by U.S. armed forces, a brief orientation to the 143 articles within the VI parts and Annex I is needed. Part I, “General Provisions” contains 11 articles. Article 3 provides a minimum standard of treatment required to persons that are no longer capable of participating in hostilities due to sickness, wounds, detention or by any other cause, in cases of armed conflict not of an international character. A thorough description of who is entitled to prisoner of war status and afforded additional protection is provided within Article 4. To receive prisoner of war status, a member of a militia or volunteer corps must meet four conditions; be commanded by a responsible person, have a fixed sign visible at a distance, carry arms openly and conduct operations in accordance with the laws and customs of war.

Part II, “General Protection of Prisoners of War” consists of 5 articles (12-16) that describe specific protections and rights for persons afforded prisoner of war status described in Article 4. Article 15 states that prisoners of war will receive medical attention required by their state of health, free of charge by the detaining power.

Part III, “Captivity” consists of 92 articles (17-108) that comprehensively regulate every aspect of treatment of EPW from the moment of capture until repatriation. There are two specific articles that address medical treatment for EPW. Article 30 directs that every camp have an adequate infirmary where prisoners of war may receive the attention they require and if necessary, the establishment of isolation wards for contagious or mental disease. Prisoners of war suffering from serious disease, surgery or hospitalization must be admitted to a military or civilian medical unit where treatment can be provided. Care and rehabilitation to disabled or blind EPW, pending repatriation, will be made available at special facilities. Article 30 reemphasizes that the cost of treatment, including apparatus necessary for the maintenance of good health, particularly dentures, eye glasses and prosthetics, will be absorbed by the Detaining Power. Article 31 addresses the frequency and purpose of medical examinations and requires that an EPW receive a medical inspection at least once a month to monitor the general health, nutrition, cleanliness and detection of contagious diseases (The Avalon Project, 1996).

Part IV, “Termination of Captivity,” contains three sections, Articles (109-121). Section One describes the repatriation process and disposition of seriously sick or wounded prisoners. Article 109 directs Parties of the conflict to send prisoners of war that are seriously wounded and seriously sick to their country of origination, after having cared for them until they are fit to travel. Article 110 describes the mechanisms and who

is eligible for direct repatriation and who can accommodated in a neutral country. Great detail of injuries or illness that qualifies a person for direct repatriation or accommodation in a neutral country is provided in Annex I of the convention. Article 112 addresses the appointment of Mixed Medical Commissions (MMC) at the onset of hostile activities. The purpose of the MMC is to examine sick and wounded prisoners of war and to make all appropriate decisions regarding them. The appointment, duty and function of the MMC are described in Annex II. Those prisoners that are seriously injured or sick as deemed by the Detaining Power's medical authorities, may be repatriated without having been examined by a MMC. Section Two addresses the release and repatriation of prisoners at the end of hostilities. Section Three provides instruction to the parties of the process of reporting and handling the remains of prisoners who die while in captivity.

Part V, "Information Bureau and Relief Societies for Prisoners of War," contains four articles (122-125). These articles provide guidance to the parties of a conflict how to establish and operate offices that track EPWs. Part VI, "Execution of the Convention," contains the final 13 Articles of the convention (126-143). Part VI provides instructions for implementing or denouncing the convention.

Annex I, "Principles for Direct Repatriation and Accommodation in Neutral Countries," is very detailed in the type of injuries or illness that would qualify a prisoner for direct repatriation or accommodation in a neutral country. A prisoner will be eligible for accommodation in a neutral country if they are unlikely to recover in captivity (The Avalon Project, 1996).

Annex II, "Regulations Concerning Mixed Medical Commissions" provides detailed instructions about the composition, roles and responsibilities of the commission.

The commission is comprised of three members, two from neutral countries and one from the Detaining Power. The position of chairman, appointed by the ICRC, will be held by a member from a neutral country. The purpose of the commission is to examine the prisoners and propose repatriation, rejection of repatriation, or defer to an examination scheduled for a later date. Their decisions are made by a majority vote and presented to the Detaining Power, the Protecting Power and the ICRC. The Detaining Power is the organization in which physically detainees a person alleged to have committed offenses and is responsible for the health and welfare of the prisoners. A Protecting Power is given custody of prisoners but the Detaining Power maintains ultimate responsibility of the health and welfare of the prisoners. The Detaining Power is required to carry out the decisions of the MMC within three months from receipt of the decision. In the event that there is no neutral physician in a country where the services of a MMC seem to be required and impossible to appoint neutral doctors resident in another country, the Detaining Power, acting in agreement with the Protecting Power, will establish a Medical Commission to accept the same duties as a MMC. Currently, the U.S. armed forces do not have an agreement with a Protecting Power and solely perform the role of the MMC. Prior to ratification of the Geneva Conventions by the U.S. government, the U.S. armed forces would face their first test to the application of the GPW.

Hostilities in Korea began on 25 June 1950, nearly six years before the U.S. Senate ratified the Geneva Convention but on 23 July 1950, the Commander in Chief United Nations Command (CINCUNC), Far East (CINCFE), General Douglas MacArthur, announced the United Nations Command (UNC) adopted the provisions of the 1949 Prisoner of War Convention. This is noteworthy because neither the U.S. nor

the United Nations (UN) fully endorsed the convention at this time. On 10 July 1950, roughly two weeks after the commencement of the North Korean invasion, the Pusan Base Command provost marshal identified the requirement to establish an EPW camp. The speed of the invasion did not permit the necessary time to develop adequate plans for the care of EPW which placed the provost marshal in a reactive mode to build the necessary facilities and acquire the required supplies for nearly 2,000 EPW. The Eighth U.S. Army, Korea (EUSAK), was assigned the responsibility for EPW administration on 1 August 1950. By the end of that month, 1,899 EPW were being held by UNC forces. A massive influx of nearly 8,900 prisoners resulted from the Inchon landings and subsequent withdrawal of North Korean forces in September. The number of prisoners grew to over 62,500 when the Chinese Army crossed the Yalu River in November and by the close of 1950, over 137,000 prisoners were held in UNC camps around Pusan. Initial planning called for creating facilities for 60,000 prisoners (Gebhardt 2005, 16).

During the initial phases of the Korean War, hospital support for the theater of operation was critically short. In response to the growing prisoner population, by 1952 the U.S. committed three field hospitals and two medical clearing companies that operated a total of nine POW hospitals. Two field hospitals were engaged in treating prisoners in Pusan throughout the conflict with another field hospital being established at a camp in Koje-do in April 1951. A statistical study of the workload by military medical treatment facilities in Korea reveals that on an average day in 1952, 76 percent of the total beds occupied were occupied by prisoners. The study also revealed that the average duration of hospitalization for a prisoner was 76.8 days, seven times longer than any other category of patient (Reister, 68). Though the UNC did not always meet the stringent

criteria of the Geneva Conventions, ICRC reports infer that great efforts were being made (Gebhardt 2005, 27).

U.S. Army doctrinal revision occurred at the conclusion of the Korean War. Two new publications, FM 27-10, *The Law of Land Warfare*, and Department of the Army Pamphlet 27-1, *Treaties Governing Land Warfare*, incorporated the provisions of the Geneva Convention and were published in July 1956. The most significant doctrinal revision comes from FM 19-40, *Enemy Prisoners of War and Civilian Internees,* published in 1967. Without referencing any particular provision, paragraph 1-4, *Basic Considerations*, of FM 19-40 stated:

> In the treatment of PW's and civilian internees, the United Sates is governed by the Geneva Conventions of 1949 and by customary law of land warfare. The governing intent of these conventions is to provide for the humane treatment of PW's and the civilian population by the parties to a conflict. The United States has ratified all four conventions and they are legally binding on the Armed Forces of the United States (FM 19-40 1967, 1-2).

FM 19-40 also defined the responsibilities of the organic medical section, consisting of four enlisted medical personnel, assigned to Company Headquarter, U.S. Military Police Prisoner of War unit, a battalion-sized organization. The medical section provided Level I care for internees and camp military personnel, consisting of preventive medicine services, lice and vermin eradication, and vaccinations (FM 19-40 1967, 7-3). The actual protocol of treating prisoners of war was referenced to FM 8-10, *Medical Service, Theater of Operations*. The 1959 edition of FM 8-10 contained the following guidance to the treatment of prisoners of war:

> Prisoners of war patients are given the same treatment and are evacuated the same as all other patients. Prisoners of war who are fit for duty are transferred to a PW enclosure. Retention for duty in the treatment facility must be authorized by higher authority. The necessity for providing guards for prisoners of war and

> procurement of the guards must be decided by higher authority. (FM 8-10 1959, 69)

No further refinement was made to these manuals after 1964, nearly a year before major ground operations in Vietnam.

Military operations during the Vietnam War posed a set of interesting challenges to the execution of U.S. policy pertaining to prisoners of war. First, the North and South governments of Vietnam did not recognize the legitimacy of the other and the U.S. did not recognize North Vietnam as a legitimate government. Second, a decision was made by the commander of the Military Assistance Command Vietnam (MACV) to release all individuals captured by U.S. units to South Vietnamese custody (Clarke 1988, 119). Under Article 12 of GPW, transfer of internees does not relieve the Detaining Power of responsibility. Because the Saigon government viewed captured Viet Cong (VC) as political prisoners, the government often held individuals in civilian jails without due process. In October 1965, the U.S. and South Vietnamese governments formed a joint committee address issues related to the Geneva Conventions. Training for soldiers and units in the field, apply the Geneva Conventions to all prisoners captured by US, Vietnamese and Free World forces and construction of five EPW camps manned by Vietnamese military police with U.S. military police as advisors resulted from the joint committee's initial efforts (Gebhardt 2005, 41).

In August 1966, the Commander, United States Military Assistance Command Vietnam (COMUSMACV), General Westmoreland, issued letters to his major commanders emphasizing his interest in the adherence to international laws in handling of EPW and combat captives. Subsequently, in October 1966 a MACV command information bulletin was published titled, "Application of the Geneva Prisoner of War

Conventions in Vietnam." The bulletin stated that members of the Viet Cong and North Vietnamese soldiers would receive prisoner of war treatment, regardless if "captured in combat or not, as long as they were not criminals, spies, saboteurs, or terrorists" (Prugh, 1973). Throughout the remainder of the Vietnam War, the COMUSMACV and staff struggled with the South Vietnamese government and armed forces to comply with GPW.

At the onset of hostilities in Vietnam in 1965, POW patients received treatment in U.S. military medical facilities near the point of capture. As the number of prisoners increased and policy changed in 1966, 100-bed medical facilities for the care of POWs were constructed at Long Binh and Phu Thanh. Eventually, these facilities were expanded into 250-bed hospitals with complete surgical resources. In 1968, the daily POW patient load increased, on average, from 250 to 400. Patient load remained constant through the first half of 1969. The average length of hospitalization for a wounded POW was 135 days and each hospital had a 75 percent bed occupancy rate (Neel 1991, 60).

After the Vietnam War, a revision to U.S. Army doctrine took place. The 1976 edition of FM 19-40 added a section entitled "Sanitation and Medical Care" that reflected requirements outlined in GPW that monthly medical inspections and weighing of PW occurred, provisions made to isolate communicable disease cases, disinfection and immunizations (FM 19-40 1976, 3-12). No significant changes were made to the roles and responsibilities of the medical section assigned to Company Headquarters, Military Police Prisoner of War unit. However, there was a reference made that an Area and Unit Medical Support Team may be attached to Company Headquarter, Military Police Prisoner of War unit to perform medical processing actions. The support unit was capable of providing medical examinations, immunizations, assisting in disinfestations, initiating

PW medical records, limited pharmacy, X-ray and ground evacuation assets (TOE, 1975). Field Manual 8-10, 1970, added three paragraphs explaining requirements for treating prisoners of war. These paragraphs required that sick, injured, or wounded prisoners be treated and evacuated through normal medical channels but physically separated from U.S. and Allied patients, evacuation from the combat zone will occur as soon as possible and a caution that medical units may require reinforcement to support the PW patient workload (FM 8-10 1970, 2-4).

Operations Urgent Fury in Grenada and Just Cause in Panama provided opportunities for the U.S. military to further test EPW medical healthcare doctrine. Due to lack of planning time before commencement of Operation Urgent Fury, EPW issues were not considered. The Joint Chiefs of Staff (JCS) issued the warning order late on 19 October and the operation began early morning of 25 October. By the evening of the first day, a Marine contingent had captured 12 Cuban airmen and by the end of the second day, approximately 250 people were detained in a temporary enclosure. Among the detained persons were doctors and nurses that provided limited medical care to other injured detainees. As the number of detainees grew, the JCS became concerned and on 27 October directed Admiral Wesley McDonald to repatriate the wounded Cubans as soon as possible. On 2 November, 57 wounded Cubans and 10 medical staff began their repatriation process. Due to greater time allocated for planning, U.S. forces involved in Operation Just Cause were better prepared to handle an EPW population nearly five times greater than what U.S. forces faced in Grenada (Gebhardt 2005, 71). Prior to the start of the operation, a site was selected for the central detainee collection camp (CDCC). The selection of the site permitted pre-positioning of construction materials. From 20

December 1989 to 15 February 1990, the CDCC processed nearly 4,000 detainees. U.S. medical personnel screened the detainees for medical problems or special needs. Detainees diagnosed with communicable diseases were immediately isolated and treated. Retained personnel were permitted to attend to other detainees using medical supplies from U.S. channels and the Fort Amador Panamanian Defense Force Infirmary (Govern 2004, 3). Though both operations were relatively short in duration involving the capture, detention, repatriation of detainees Operation Just Cause provides concrete evidence to the importance of determining requirements and planning for detainees during military operations (Gebhardt 2005, 69).

Operation Desert Storm presented some unique challenges to the application of Geneva Conventions and U.S. Army doctrine. Though the ground war was executed and met military objectives within 100 hours, EPWs were captured a month prior and remained a concern until 5 August 2001 (Gebhardt 2005, 85). During the operation approximately 62,000 EPWs were interned at two US-controlled sites in Saudi Arabia, East Camp and West Camp. Of the 62,000 EPWs roughly 20,000 required some degree of medical care. EPWs interned at East Camp were offered medical care provided by the 300th Field Hospital that established a 400 bed facility. Prior to the ground war, nearly 20 percent of the EPW population attended sick call. This number of EPWs attending sick call after the start of the ground war declined. The most probable explanation to the decrease is the conditions of capture. Deserters that left their positions during the U.S. air bombardment were faced with several days of walking in the harsh desert conditions or received stricter treatment by military police than those captured in larger numbers, usually as a unit, after the ground war. Among the captured were Iraqi physicians that

were permitted to assist in sick call procedures in accordance with the Geneva Conventions. At the height of the prisoner population, daily sick call averaged 700 patients per day. From 24 February to 30 March, approximately 8,797 patients were treated (Desmuckh and Longmire 1991, 647). The most prevalent complaint was toothache, accounting for nearly one-quarter of all patients treated. Other commonly encountered medical conditions were upper respiratory infections, headaches, urinary tract infections, skin diseases, trauma and diarrhea. Insulin-dependant diabetes, Parkinson's disease and schizophrenia were also diagnosed and treated at East Camp. The sheer number and types of chronic medical conditions were not fully anticipated by the medical staff and posed a significant logistical challenge to overcome. The physicians of the 300th Field Hospital had difficulty identifying which EPW required immunization for tetanus. Captured Iraqi doctors revealed that only the Republican Guard could be assumed appropriately vaccinated. Apparently, the Iraqi Army desired to increase the size of the fighting force, but did very little in the way of medical screening before conscripting a soldier (Keenan 1991, 650). Though planning for detainee medical healthcare took place prior to operations, there was a shortfall in adequately planning for the complexities of the detainee healthcare mission causing undue stress to medical providers and the logistical system.

In order to provide a different perspective related to the treatment and patient workload of detainees, Lieutenant Colonel (Lt Col) Jeremy John Hobart Tuck of the Royal Army Medical Corps, British Army, published an article based on his experience during Operation Telic, 2001. Operation Telic was the United Kingdom's contribution to enforce Iraq's compliance with United Nations Security Council Resolution 1441,

identification and destruction of weapons of mass destruction. The RAMC began planning for EPW medical care prior to deploying using the Geneva Conventions and "current doctrine." Lt Col Tuck cited Joint Publication (JP) 1-10, *Prisoner of War Handling*; JP 4-00, *Joint Logistics*; and JP 4-03, *Joint Medical Doctrine*, all printed in Washington, DC. The campaign began on 20 March; by 25 March the EPW holding group crossed the border into Iraq and established their area of operations vicinity Umm Qasar located in the southeast portion of Iraq. Within five days of arriving, 30 March, the population at the EPW holding area had grown to approximately 3,000 EPW and by 15 April; the population had doubled to nearly 6,000 EPW. Lt Col Tuck remarked at some similarities in the medical cases as previously experienced by the 300th Field Hospital during Operation Desert Storm. Dental disease remained prevalent among the prisoners, accounting for approximately 15 percent of the clinic's daily work load. Within 22 days, 236 simple extractions and 69 surgical extractions were performed. Traumatic injuries accounted for nearly 26 percent of the daily clinic activity. Other common illness or diseases were musculoskeletal, gastrointestinal and respiratory infection. Lt Col Tuck included in his article that "appropriate medical support for EPW remains an issue of military and medical importance" (Tuck 2005, 181).

For the purpose of this study, an examination of current DOD directives and instructions that directly impact U.S. Army regulations and doctrine is needed. DOD Directive (DODD) 2310.1E, *Detainee Program*, has the purpose of ensuring compliance with the laws of the United States, law of war, including the Geneva Conventions of 1949 and re-designates the Secretary of the Army as the DOD Executive Agent for the Administration of Department of Defense Detainee Operations Policy. The directive also

states that at minimum DOD personnel will apply the standards articulated in Common Article 3 to the Geneva Conventions of 1949 regardless of a detainee's legal status. Enclosure 2, Definitions, contains two very relative definitions for this study. DOD defines a detainee as any person captured, detained, held, or otherwise under the control of DOD personnel (military, civilian, or contractor employee) but does not include persons being held primarily for law enforcement purposes, except where the United States is the occupying power. Another definition is listed for unlawful enemy combatants and again, is very specific. In accordance with DOD, an unlawful combatant is not entitled to combatant immunity when engaged in acts against U.S. or coalition partners or is in violation of the laws and customs of war during conflict. Further delineation is made for the purposes of the war on terrorism. "An individual who is or was part of or supporting Taliban or al Qaeda forces or associated forces engaged in hostilities against the United States or its coalition partners is an unlawful combatant" (DODD 2006).

DOD Instruction (DODI) 2310.08E, Medical Program Support for Detainee Operations was published 6 June 2006. This instruction defined the roles and responsibilities of healthcare personnel treating detainees.

> Healthcare personnel have a duty in all matters affecting the physical and mental health of detainees to perform, encourage, and support, directly and indirectly, actions to uphold the humane treatment of detainees and to ensure that no individual in the custody or under the physical control of the Department of Defense, regardless of nationality or physical location, shall be subject to cruel, inhuman, or degrading treatment or punishment, in accordance with and as defined in U.S. law. (DODI, 2006)

Treatment of detainees should be guided by the professional judgments and standards similar to those applied to personnel of the U.S. armed forces (DODI 2006).

Within Army regulations, AR 190-8, *Enemy Prisoners of War, Retained Personnel, Civilian Internees and Detainees,* contains the most inclusive list for medical treatment for detained persons. The naming scheme for ARs is done by series collections. A noteworthy point is that AR 190-8 falls under the Military Police series and provides greater detail to medical treatment of detainees than ARs under the Army Medical Department. Chapter 6, "Administration and Operation of CI Internment Facilities," contains the medical care and sanitation section. In general, each CI will be medically examined upon arrival and each month during internment. Dental, surgical, spectacles required artificial appliances and medical treatment will be free to the CI and immunized in accordance with theater policy. Each CI camp will provide adequate routine and emergency treatment. When feasible, a patient will be moved to a civilian hospital but the treatment must be as good as that provided to the general population. When civilian hospitals are not available or their use is not feasible due to security reasons, U.S. military hospitals may be used (AR 190-8 1997, 22).

A primary concern to this study is the state of the Iraqi medical system. As of 28 January 2007, a common reported topic has emphasized lack of security, shortage of medical supplies, medicine, equipment and specialized staff will cause a major medical crisis in Iraq. A representative from the ICRC has claimed that over half of the 34,000 doctors in Iraq have fled the country because physicians and other medical staff are often targets for kidnappers (Office of the United Nations High Commissioner for Human Rights). Since 2003, more than 160 nurses have been killed, more than 400 wounded and many more have also fled the country. Efforts to relieve the extra burden on the physicians currently working, the USAID has provided skills training to more than 3,200

physicians and established training centers in five different locations (Office of the United Nations High Commissioner for Human Rights). Obviously, the security situation in Iraq has countrywide effects and is the primary reason that about 12 percent of reconstruction projects are delayed (DOD, 2007). The revitalization process of Iraq's healthcare system will take years in order to adequately provide medical care to Iraqi citizens.

According to the Ministry of Health, the U.S. government has spent nearly $1 billion (US) on Iraq's healthcare system but $8 billion (US) is required over the next four years to reach a level capable of providing the required medical care throughout Iraq (Office of the United Nations High Commissioner for Human Rights). As of 1 March 2007, the U.S. committed $22 million to Iraq's construction effort. During a news briefing held on 1 March 2007 from Baghdad, Iraq, Brigadier General Walsh, Commander of the Gulf Region Division, Army Corps of Engineers and Director of the Baghdad Project Contracting Office, claimed progress in healthcare was being made, including the Basra Children's Hospital, a 94-bed facility, that will provide acute care and pediatric oncology scheduled for completion in late 2008. Other facilities continue to be built as turn-key projects where the structures include medical and dental equipment needed to operate the facility (DOD 2007).

On 6 March 2007, the U.S. Department of State released the *Country Reports of Human Rights Pratices – 2006* report. This 21-page report provided, in great detail, information pertaining to events that occurred in Iraq throughout 2006. The *Prison and Detention Center Conditions* section of the report addressed the management, operation and medical care. Iraqi law mandates that all detention facilities be controlled by the

Ministry of Justice (MOJ). However, in fact detention facilities were operated by four separate ministries: Justice, Interior, Defense and the Ministry of Labor and Social Affairs. According to the United Nations Assistance Mission for Iraq (UNAMI), general conditions were inconsistent with international human rights standards. Facilities controlled by MOJ provided satisfactory medical care and exceeded the community standard in some locations. However, many facilities controlled by Ministry of Interior and Ministry of Defense routinely lacked adequate medical care or medical care was not provided at all. By the end of 2006, official MOI detention facilities were estimated to number over 1,000 but a definitive number of detention facilities were unknown (U.S. Department of State, 2006).

As the literature review has demonstrated, there is a need to conduct a study of the laws, instructions, directives, regulations, doctrine, Iraqi capabilities, and U.S. obligations to determine whether or not a transition plan can be developed to allow the Iraqi government to assume the medical operations for detention operations. The categorization of detained persons has changed since the events of 11 September 2001, and the military is responding to changes in policy and doctrine. Congress, DOD and the U.S. Army have identified shortfalls in current policy and doctrine, while the United States Agency for International Development (USAID) and the Army Corps of Engineers continue to express concerns on the timeliness of reconstruction projects.

Chapter 3, “Research Methodology,” will outline in detail the specific research methods and techniques used in this study.

CHAPTER 3

RESEARCH METHODOLOGY

In the last chapter, the review of literature demonstrated there is a need to conduct a study of the laws, instructions, directives, regulations, doctrine, Iraqi capabilities, and U.S. obligations to determine whether of not a transition plan can be developed to allow the Iraqi government to assume the medical operations for detention operations. The purpose of this study is to examine current requirements for conducting healthcare for detained persons by United States (US) armed forces involved in Operation Iraqi Freedom (OIF) and explore the challenges associated in developing a comprehensive plan to transition detention operations to indigenous Iraqi forces. Ideally, the solution to a detention healthcare operation transition would be developed by the Iraqi government.

The purpose of this chapter is to describe the research methodology used in the study. Historical applications of international law, U.S. law, conventions, policy, and doctrine by U.S. armed forces during combat operations, U.S. legal documentation, Department of Defense instructions and directives and Department of the Army regulations and doctrine were reviewed and analyzed in order to understand U.S. policy and law development. The purpose is to develop an understanding of the complexities involved in detention operations, specifically, detainee healthcare operations. An additional purpose was to determine whether or not contradictions exists between current U.S. laws, policies, directives, regulations, and doctrine. Analysis and examination of U.S. governmental memorandums, DOD directives, interim guidance, current or draft U.S. Army regulations, and doctrine was conducted to determine whether or not

interpretations of these authoritative documents could cause confusion for U.S. armed forces implementing and conducting detention operations. Further research and analysis was completed to examine possible changes to current U.S. Army regulations or doctrine and interpretation of international treaties and conventions or U.S. laws by U.S. governmental agencies in regards to classification, medical treatment and disposition of detained personnel.

After determining what the current policy is, the next step is to determine the required level of medical treatment afforded detainees through review and analysis of current or draft DOD directives or instruction, U.S. law and applicable international law pertaining to the medical treatment of detained persons. Examination of U.S. presidential memorandum dated January 2002, Department of Justice memorandums containing legal review and recommendations to the U.S. president, DOD directives, interim guidance published by Headquarters, U.S. Medical Command, Fort Sam Houston, and U.S. Army regulatory and doctrinal publications on classification and treatment of detained personnel was conducted in order to determine requirements for detainee healthcare and determine if medical treatment differs for the various categories of detained persons.

Analysis of international treaties and conventions was conducted to determine the governing body of international detention standards and the ability of an international organization to enforce published standards. The primary purpose of reviewing international treaties was to determine if there was a definitive level of care required for detained personnel. The secondary purpose was to determine current U.S. policy related to the classification and medical treatment of detained personnel. This research was also designed to determine the governing body of established international detention standards

and the ability to enforce the standards. Additional research was completed to determine the necessary conditions to relinquish control of a detained person from the Detaining Power to another party.

To determine the current state and projected status of Iraq's healthcare system review and analysis of literature made available from the Armed Forces Medical Intelligence Center (AFMIC), U.S. Department of State, United States Agency for International Development (USAID), press releases and open media sources was completed. The primary purpose was to determine the current status of the Iraq healthcare system and determine whether or not the healthcare system could appropriately absorb the detainee healthcare workload. Further research was completed on current detention and prison facilities operating under the control of the Iraqi government to gain an understanding of current capabilities

The primary difficulty was the overwhelming number of articles addressing prisoner abuse and interrogations and the availability of published articles relating to detainee healthcare. As efforts continue throughout Iraq and the international community, the situation is constantly changing. Additionally, DOD is developing Joint doctrine which is still in draft phase. Classification of reports also remained an issue during the research. Classification of this study remains unclassified; therefore, certain programs implemented or planned by the coalition could not be included in this study.

Chapter 4, "Analysis," will analyze whether or not in light of international guidelines, Iraqi capabilities and U.S. obligations a transition plan can be developed to allow the Iraqi government to assume the medical operations for detention operations. Also, determine if U.S. law and policy conform to international standards and determine

if current U.S. Army regulations and doctrine need revision to comply with current DOD policy or U.S. law.

CHAPTER 4

ANALYSIS

The purpose of this chapter is to present an analysis of policy, regulations and doctrine governing requirements for U.S. armed forces conducting detention medical operations and the current status and near-term projection of Iraq's healthcare system and explain research findings to determine if development of a transition plan is feasible. As long as the U.S. remains a world power and execute the Global War on Terror, the issue of detention operations will remain a concern for U.S. armed forces. Because of decisions by the Bush administration at the beginning of the Global War on Terror not to provide al-Qaeda and Taliban militia protection under the Geneva convention, the interpretation and application of international treaties and conventions by the U.S. government will remain under the watchful eye of the international community making it is vitally important that we conduct any turn-over the right way.

In the last chapter, the author detailed a methodology for determining if a transition plan can be developed to allow the Iraqi government to assume the medical operations involved with detention operations based on international guidelines, Iraqi capabilities and U.S. obligations. Initially, analysis of U.S. policy governing detention operations is needed to determine the requirements for U.S. armed forces conducting detention operations and determine if the U.S. armed forces are meeting these requirements.

The most recent DOD level policy on the treatment of detainees in custody of U.S. armed forces is provided in DODD 2310.1E. However, after analyzing the DODD,

the directive falls short in providing enough information for the Secretary of the Army to develop an executable plan. The directive does not provide parameters for U.S. armed forces to operate within. Arguably, the minimum amount of healthcare required for a detainee in U.S. custody is addressed within the directive as meeting the guidelines set within U.S. law and Common Article 3 of the Geneva Conventions. Though still vague, U.S. law and Common Article 3 of the Geneva Conventions does provide a minimal medical standard to achieve. However, no upper limitation is set as to the upper extent of care that can be provided to detainees while in U.S. custody. A direct correlation of not having an upper extent of medical treatment for detainees can be made with the current situation faced by U.S. armed forces in Iraq. There were, and still may be, discussions of deploying an eye specialist team from the U.S. into Iraq, to perform cataract surgery for detainees in U.S. custody. This type of procedure is well outside any detainee healthcare service mandated by current U.S. law, Army regulation or doctrine, surpasses the medical treatment of detainees directed by the Geneva Conventions and AMEDD guidance to provide care equal to that provided to U.S. armed forces in the area.

Conversely, wording of a directive that restricts the extent of care authorized, could unnecessarily bind the U.S. armed forces or medical care providers conducting detention healthcare from executing good ethical and moral judgment. Predicting every plausible situation where U.S. medical personnel may be employed, along with predicting every medical condition that U.S. medical personnel could encounter is impossible. As a global superpower, there are, arguably, expectations that U.S. armed forces will provide a higher level of medical care to the injured or sick in their custody than a lesser power would provide. Permitting an individual to die within a U.S. medical facility because

their injuries surpassed the authorized extent of care would certainly be unacceptable to U.S. citizens and internationally. Therefore, a directive too prescriptive could hinder the Secretary of the Army's ability to develop a suitable policy.

Having a policy directing the provision of a certain level of healthcare, medical services and medical assistance programs by U.S. armed forces conducting detention operations would remove confusion for Combatant Commanders and enhance the planning process to avoid shortfalls in detention healthcare. Some examples covering healthcare provision limits would include elective procedures not provided to U.S. armed forces in the area, such as wart removal, scar tissue reduction, or bunion removal to name a few. Additionally, a panel of physicians should provide consensual guidelines on resuscitative procedures and euthanasia. These topics do not have clear cut or easy answers but are required by healthcare providers. The entire burden to make such decisions should not be placed on the medical staff conducting operations. However, medical care providers must ensure all necessary actions are taken to preserve life, limb or eyesight of all patients, regardless of category; treat injuries and medical conditions of detainees within the capabilities of the detention medical facility; and apply the standards of care outlined within the GPW and AR 190-8. At a minimum, the DODD should change the wording of the directive to clarify whether U.S. armed forces are required to apply the GPW in force, which is U.S. law, or apply at the minimum the standards identified in Common Article 3 of the Geneva Conventions. Because of the vagueness of Common Article 3 of the Geneva Conventions, a determination of the medical care required under the premise of "the wounded and sick shall be collected and cared for" should be made (The Avalon Project). Clarification to the directive would assist AMEDD

personnel in determining appropriate medical personnel staffing and types of equipment necessary to provide detainees in custody of U.S. armed forces the required level of medical treatment.

The next step is to determine what the actual required level of care is for detainees under the custody of U.S. armed forces in Iraq. In accordance with the GPW, DODD and U.S. Army regulations and doctrine, the level of care provided to detained personnel equates to Level IV medical care provided to U.S. armed forces. Current U.S. military detainee medical operations provide detainees with the correct level of care (AMEDD Memo, 2005). The 115th FH deployed in 2004 and established a Level IV medical treatment facility at Abu Ghraib, Iraq which served as the Theater Internment Facility (TIF). Subsequently, a second TIF was established at Camp Bucca, near Umm Qasr, Iraq and a second Level IV medical treatment facility was established by the 115th FH. The 115th FH conducted a transfer of authority with the 344th CSH in July, 2005. U.S. armed forces have the capability to meet detainee healthcare operations requirements but there is concern about the ability to sustain the required level of care. Currently, the U.S. Army Medical Department is conducting force modernization through the Medical Re-Engineering Initiative. When complete, the CSH will be the only hospital in the Army inventory (SB8-75-S4, 2006, 4-1). This change primarily affects the long-term rehabilitative care of the medical treatment facility. As depicted in figure 1, a CSH does not have occupational therapy or minimal care capabilities organic to the organization which are critical components of Level IV medical care.

Table 1. Capability Comparison between Level III (CSH) and Level IV (FH)		
Capability	Level III	Level IV
Hospitalization	248 patients	504 patients
Surgery	6 operating tables	1 operating table
Minimal and Convalescent Care	Minimal care detachment must be added	Minimal care up to 40 patients and convalescent care up to 280 patients
Rehabilitative Services	Physical therapy	Physical and occupational therapy

Source: Headquarters, Department of the Army. FM 8-55, *Planning for Health Service Support* (Washington, DC: Government Printing Office, 1994), A4.

Historical analysis shows detainees can remain in U.S. custody, generally, several months but in extreme circumstances, several years. As long as a detainee is under U.S. custody, appropriate medical care is required. An example of a limitation of a CSH performing the role of a Level IV medical treatment facility is the Physical Therapy section. The current CSH TOE authorizes only one physical therapist, when the physical pherapist leaves Iraq for authorized rest and relaxation (R&R) leave, the physical therapy section is not operational for a period up to 23 days, suspending physical therapy treatment during this time.

The detention medical healthcare mission was assigned the 344th CSH as a unit and not based on the unit's capability. After receiving the deployment order and notification of the detention medical healthcare mission, the 344th CSH staff identified shortfalls in personnel required to meet mission requirements. The identified personnel shortfalls and request to adjust the authorized manning document was submitted to the United States Army Reserve Command (USARC), Surgeon's Office. Because of strict limitations on the number of soldiers permitted for each unit in Iraq, requests to adjust the

authorized manning document required approval from the Combatant Commander. The entire process to make the needed adjustments to the authorized manning document took several weeks causing delays in personnel arriving to the mobilization station to prepare for deployment. Sporadic arrival of soldiers to the mobilization station caused disruptions and repetition of training events and deployment timelines. The end result was 344th CSH having to deploy to Iraq in two segments causing a shortage of personnel for nearly 30 days. Deployment of equipment needed for the mission was not a concern as the 344th CSH was authorized by the Combatant Command to assume responsibility for the equipment from the 115th FH. Through this process, the equipment authorized in the occupational and physical therapy sections of the 115th FH would remain in the theater of operation for use by the 344th CSH negating further requisition of additional equipment. If this had not been the case, 344th CSH would have had to requisition equipment and supplies in order to perform the mission of a Level IV medical treatment facility possibly causing a substantial delay in providing occupational and physical therapy treatment. Though the CSH does not have the capability to conduct Level IV healthcare, the capability still exists in the U.S. Army inventory.

The components to conduct Level IV have been developed into minimal care detachments that have the mission to provide convalescent care and rehabilitative services in support of theater hospitals. But, because the mission was assigned to the 334th CSH and limitations on the number of soldiers permitted on the authorized manning document, augmentation from a minimal care detachment was not permitted. With Level IV deployable medical treatment facilities transitioning to Level III, there is a concern that U.S. armed forces will not have the capability to adequately perform

detention medical operations. To mitigate this concern, effective mission analysis is necessary to ensure the mission of detainee medical operations is assigned to a unit with the capability of meeting mission requirements or streamline the process to request and approve changes to the authorized manning documents. Regardless of what type of unit is assigned to conduct detainee medical operations, the unit must be resourced to meet mission requirements.

A comprehensive review of U.S. Army regulations and doctrine pertaining to detention operations is needed to remove conflicting information. Analysis of the DODD showed how vagueness and unclear guidance leaves the interpretation to the reader and could lead to underestimating mission requirements. Similarly, disparities with U.S. Army regulations and doctrine exist concerning what is the minimal and upper extent of medical treatment afforded detainees. From the point of capture to the TIF, the goal is 48 hours to move a detained person through different tiers of the detention system. Two primary stopping points are the Brigade Internment Facility (BIF) and the Division Internment Facility (DIF). Current doctrine does not address what level of medical care is required at these locations. Arguably, the guidance stating detainees should receive medical care similar to that of U.S. forces in the area provides the minimal standards required at a BIF of DIF. At brigade and division levels, medical care equates to Level II care. However, the application of Brigade and Division care equating to Level II care is designed for a linear battlefield. In the nonlinear environment like Iraq, a CSH could be located on the same Forward Operating Base (FOB) from which a U.S. maneuver force draws support and relative proximity to a BIF. Would the proximity of the CSH to the BIF afford detained persons, without life threatening injuries, Level III medical treatment

or would the detainee have to wait to arrive at the TIF for Level III care? With rapid movement from point of capture until arrival at the TIF, the detainee should wait for definitive medical care, dependant on injuries, until arrival at the TIF due to guard reasons. Each detainee that goes to a medical treatment facility outside the TIF's medical treatment facility is accompanied by a U.S. soldier tasked to guard the detainee. One approach to resolve discrepancies among U.S. Army regulations and doctrine, a working group, consisting of representatives from at least the U.S. Army's Staff Judge Advocate, Military Police and Medical Department, should convene and approach detention operations collectively and not individual branches in order to promote unity of effort during operations. Another approach is the appointment of a Detainee Operations Directorate within the U.S. Army to systematically remove discrepancies in current doctrine or develop a new doctrinal manual for detention operations that would supersede current doctrinal manuals constructing a common operating picture for all branches to follow.

As the U.S. to work with the Iraqi government, understanding applicable international standards for detainee healthcare is essential to maintain positive relations and develop a common understanding in effort to develop a detention medical transition plan. As determined through chapter 2, an all encompassing international standard does not exist but rather a collection of declarations, principles, guidelines, standard rules and recommendations that have a varying legal effect depending on whether the State has signed and ratified. Applicable to this study, an understanding of which declarations, principles, guidelines, standard rules and recommendations the Iraqi government is party to is necessary. The Iraqi government has signed and ratified is the Geneva Conventions

of 1949 but is not party to another international pertaining to detention operations. Because Iraq is a sovereign nation and the Geneva Conventions do not govern internal cases, the Geneva Conventions has no impact on their detention program. As a sovereign nation, the Iraqi government is able to determine their own laws, guidelines and policies pertaining to operating detention facilities within their country. Though detention facilities within Iraq have been reported as being inconsistent with international human rights standards, the means in which the Iraqi government chooses to operate is their right as a nation (U.S. Department of State 2006). At the end of the day, once a detainee under U.S. custody has been processed through the Iraqi judicial system; the detainee becomes a prisoner of Iraq. However, substandard conditions within Iraq controlled detention facilities are drawing the attention of the international community. Further study is needed to determine what level of healthcare is currently being provided at Iraqi detention facilities and recommendations made on ways to enhance their detention healthcare system.

In order to determine the existing international standards, an understanding of what governing body is responsible for establishing and maintaining international detention standards is necessary. There is no single agency responsible for establishing and maintaining international detention standards. Rather, there are a number of organizations, such as Amnesty International, Detention Network USA, Human Rights First and Human Rights Watch, that establish principles for detention standards. Though all of these organizations have interests in protecting human rights there are differences between the organizations on the definition of detention. Amnesty International defines detention as a restriction of movement by governmental authorities, while the Office of

the United Nations High Commissioner for Human Rights defines detention as any person deprived of personal liberty except as a result of conviction for an offense (Office of the United Nations High Commissioner for Human Rights). The influence of many of these organizations is more political than legislative. None of the organizations have produced a set of detention principles in which the Iraqi government officially accepts as a base for their detention operations. Though these organizations intend to protect the human rights of detained persons, these organizations are virtually powerless when a nation does not want to accept their standards.

The final step is to analyze the ability of the Iraqi healthcare system to absorb the detention healthcare workload if the U.S. were to release custody of all detainees to Iraqi authorities. Under current conditions, the Iraqi healthcare system is unable to absorb workload associated with the detention healthcare mission. With over half of the 34,000 doctors in Iraq fleeing the country because physicians and other medical staff are often targets for kidnappers, there is a projection of ten years made to overcome the deficit of medical professionals in Iraq in order to provide adequate healthcare for the civilian population. An addition of nearly 1,200 detainee patients per month could not be supported with the current condition of the Iraqi healthcare system (IRIN). According to MNF-I's official webpage, in 2006, 15 hospitals were renovated allowing approximately 500 patients to be seen each day for a total of 11,000 patients being seen each month (MNF-I). Using the detainee workload data described in chapter 2, a detainee population of 14,000 would generate over 1,200 detainees requiring standard sick call per month and 12 patients requiring in-patient medical care. Based on these numbers, the current detention population in U.S. custody would require the equivalent of one hospital to

provide medical care solely to detainees. Placing such an enormous and medically diverse population on an already strained system could cause system failure, resulting in an unacceptable lowering of medical care to Iraqi citizens.

Though Iraq's Ministry of Health has developed a vision and progress is being made to revitalize the public healthcare system, the underlying question remains what is considered satisfactory for Iraqi detention healthcare and who determines when that level is achieved. What action is taken or permitted by U.S. armed forces personnel when that level of healthcare is not observed? When a detained person is released from U.S. custody to Iraqi authorities, that detained person is no longer under the responsibility of U.S. armed forces personnel. Within the latest Army doctrine concerning counterinsurgency operations, Appendix D, FM 3-24, *Counterinsurgency*, addresses transfer of detainees to the host nation. The FM states that U.S. forces may not transfer detainees to the host nation or any foreign government when there are substantial grounds that detainees would be in danger in the custody of others, including inhumane treatment (FM 2-24 2006, D-6). With documented cases from the U.S. State Department of Iraqi detention facilities controlled by MOI and MOD routinely lacking adequate medical care, to follow U.S. doctrine, detainees should not be released to Iraqi custody until improvements are made to their detention facilities. Arguably, the inadequacy of medical treatment within Iraqi detention facilities is inhumane treatment. For example, not changing a bandage on an open wound can cause the wound to become infected and develop into a wide range of health complications, including death. At the time of release from U.S. custody to Iraqi custody, U.S. armed forces do not know which detention facility a detainee will be sent. Without knowing where the detainee will be sent but

aware of the conditions in Iraq's detention facilities and knowing U.S. Army doctrine, the legality of releasing detainees to Iraqi control is questionable and thwarts a feasible transition plan being promoted by the U.S. government. However, to move forward toward a successful transition plan a change to policy is needed. Medical, legal and operational questions emerge with any possible solution. A committee of U.S. armed forces, USAID, DOJ and Iraq's MOJ will have to evaluate current condition, policies, procedures and laws to determine an acceptable solution in determining prerequisites for the transition of detainee medical operations.

CHAPTER 5

CONCLUSIONS

In the previous chapter, U.S. Army policies, directives, regulations and doctrine along with the current and projected status of the Iraqi healthcare system were analyzed to determine if a transition plan for indigenous Iraqi forces can execute the detention healthcare mission from U.S. forces. This chapter will address why a detainee medical operation transition plan is currently not achievable and highlight a few of the discrepancies between U.S. and international guidelines pertaining to detainee healthcare. Finally, this chapter will touch on some of the critical issues involved with detainee healthcare. These issues include training and equipping U.S. armed forces to conduct detainee medical operations.

As chapter 4 demonstrated, an acceptable transition plan, under current conditions, is not obtainable. In order to facilitate a detention transition plan, changes to current conditions or new developments would have to occur. The current Iraqi detention system does not mirror U.S. detention operations but does it need to operate within U.S. guidelines in order to assume control of detainees released from U.S. custody? No. As a sovereign nation, the Iraqi government is responsible to make laws for their country, adhere to international treaties to which they are party and take responsibility for the actions of subordinate Ministries. Iraqi law mandates that detention facilities operate under the MOJ however three other ministries are operating detention facilities. MOJ operated facilities provided adequate medical care to prisoners. In order to have a standard of medical care within Iraqi controlled detention facilities, the Iraqi government

must address the inadequate medical care within detention facilities operated by other ministries or completely stop detention operations at these facilities. While the mission of MNF-I is to support Iraq's ultimate goal of a unified, stable and democratic Iraq, which provides a representative government for the Iraqi people, the U.S. government has not made ultimatums to the Iraqi government specifically relating to their legal system. In fact, to the casual U.S. observer, the Hussein trial may have looked bizarre. This is because the Iraqi judicial system is based on French law. For example, a person that commits the act of stealing in the Kingdom of Saudi Arabia may have their hand or hands removed. The U.S. has maintained a military presence in Saudi Arabia since Operation Desert Storm and never requested Saudi Arabia to amend their laws to reflect U.S. law for stealing. At this point in the execution of OIF, the U.S. can not demand Iraq adapt to our legal system.

With documented cases of inadequate medical services at known Iraqi detention facilities, releasing detainees to Iraqi custody is in direct conflict with U.S. Army doctrine. This obviously raises concern that the release of detainees from U.S. custody to Iraqi custody or U.S. armed forces maintain control of detainees until Iraqi detention facilities are able to maintain an agreed upon level of medical has the potential to generate negative national or international backlashes toward U.S. actions in Iraq. There are several options available to effect the current situation in order to develop an acceptable detention medical transition plan.

One approach is to review and understand which agreements and treaties the Iraqi government is party to and the applicable Iraqi laws and policies pertaining to detention center management and operation. Once this is determined, USAID, U.S. DOJ and other

appropriate international agencies, in coordination with the MOJ, will work to define what the level of adequate medical care for detained persons. This would encourage cooperation among these agencies in order to develop an actionable plan to meet that measurable standard. Additionally, routine inspections by an agreed upon unbiased third party would ensure the agreed upon standard was achieved at each detention facility and add legitimacy to the Iraqi detention program. Not included in the process of developing a standard for medical care within Iraqi controlled detention facilities is the U.S. armed forces because of the role of the U.S. armed forces is to support the Iraqi government and not make or dictate policy toward a foreign government. Until the agreement to the level medical care is made, the U.S. armed forces would continue medical care for detainees in accordance with current DOD and Army policy and continue the transfer of detainees from U.S. to Iraqi custody. This could be perceived internationally that the U.S. is permitting Iraqis to commit human rights violations in order to facilitate an exit plan (USAID, 2006).

A second approach is closely related to the first but differs in that U.S. Armed forces would not release detainees to Iraqi custody until adequate medical services are provided at Iraqi detention facilities. With increasing U.S. political pressure for the removal of U.S. troops from Iraq, this is a feasible solution but not necessarily an acceptable solution as this relates back to the concern that the MOJ does not have to agree on the standard of medical care for detainees proposed by USAID, U.S. Department of Justice or other international agencies. Additionally, this poses questions of legality. A detainee is released to Iraqi custody only after they have been processed through the Iraqi judicial system. The U.S. armed forces do not operate facilities for Iraqi

prisoners. Additionally, this approach presents a concern for U.S. armed forces conducting detention operations. Under this approach, the detainee population would increase as U.S. armed forces would maintain custody of current detainees and military operations throughout Iraq would generate more detained persons resulting in a greater workload for U.S. armed forces conducting detention operations. During a press briefing conducted on 3 May 2007, Major General Caldwell IV, Multi-National Force-Iraq spokesman, announced that during April, 2007, 465 personnel were detained, however, no numbers of detainees released or transferred to Iraqi custody were provided (MNF-I 2007). Using anecdotal evidence, within three months, the detainee population would increase by over 1,200. The second approach, arguably, does not permit an acceptable detention medical operations transition plan being developed. This approach does keep detainees in U.S. custody, avoiding the potential for international perception that the U.S. is turning a blind eye to the reported violation of human rights in Iraq's detention facilities. However, as the detainee population would continue to grow, the requirements for more U.S. medical forces to meet the medical needs of the growing detainee population would also increase.

Conflicts, discrepancies and ambiguities within DOD policy, regulations and doctrine pertaining to the level of medical care required for detainees were discovered through the analysis conducted in chapter 4. Though revision to DOD policy and Army regulations and doctrine is a lengthy process, coordination and deconfliction of current policy and regulations is needed across the service components in order to facilitate proper planning and training for forces selected to perform this complex mission. The Final Coordination draft of Joint Publication (JP) 3-63, *Detainee Operations*, 15

December 2006, contains discrepancies. Within the “Preface,” JP 3-63 clearly states that the joint doctrine is authoritative and applies to combatant commanders, joint task forces, subordinate components of these commands and the Services. Of note, when officially signed, JP 3-63 will take precedence over Service publications. A directed responsibility of the “Medical Officer/Surgeon” is to provide Level 1 medical services to the detainee population and coordinate for Level 2 or higher medical services. Additionally, JP 3-63 requires that “Level I, II, and/or III care as operational circumstances permit” should be included when planning detainee operations (JP 3-63, 2006). First, this is an obvious conflict with AR 40-400, *Patient Administration*, that directs detained persons under U.S. custody are entitled to medical treatment of the same kind and quality provided U.S. armed forces in the area (AR 40-400, 2006). An additional discrepancy is with the medical care outlined in AR 190-8 that directs medical treatment for detainees equal Level IV medical care is reduced by JP 3-63 not to exceed Level III. With removal of the Level IV requirement, JP 3-63 is essentially dismissing the GPW. The care outlined with GPW specifically addresses care and rehabilitation of disabled EPW. According to the U.S. Army Medical Department, an element of Level IV care is rehabilitative care. Over the course of fifty plus years, the U.S. policy has been to apply the law of war during all armed conflicts and the principles of the law of war. Though the argument can be made that the U.S. chooses to comply with the principles of the law of war as a matter of policy rather than a legal obligation, by acting with a general and consistent practice under the belief it is legally obligated to do so, the U.S. has created a customary law standard that is applicable to Stability Operations, which includes GWOT (Bulman, 1999, 174). The apparent disconnect among U.S. policy, regulations and doctrine does not support the

obligations contained in U.S. law. Regardless of the ambiguity and conflicts within DOD pertaining to detention operations, U.S. Army personnel should maintain the long-held practices in support of the Geneva Conventions and continue to maintain high standards of conduct in combat. To affect the differences in policy, coordination between Service branches to provide a common operating picture would pay great dividends for future detention operations.

A step in the right direction is the implementation of specific training across the U.S. Army relating to detention operations. The U.S. Army Medical Department has developed and implemented several training programs for medical personnel. Medical personnel that are programmed to work in a detention facility and treat detainees receive the Medical Ethics and Detainee Healthcare Operations course that focuses on values, ethics and operational standards. Additionally, detention medical operations is incorporated into medical officer and enlisted training and medical pre-command courses. However, there remains a shortfall in equipment to effectively conduct the detention healthcare operation mission and planning. As described earlier, to adhere to U.S. law, Level IV is required. Currently, changes in the TOE for U.S. Army hospital units are reducing their capability to Level III. In order to perform detention healthcare operations, mission requirements will have to be re-defined, followed by obtaining the necessary equipment to fulfill the mission requirements. Of course, the personnel needed to operate the equipment or perform required medical services not organic to a Level III facility will have to be trained, including sustainment training in order to retain their skill set.

Obvious issues arise with this process. Although substantial research is required to determine equipment needs, equipment readiness, medical personnel requirements and training, there is a need to resolve these issues. Not all the questions will have answers as it is nearly impossible to predict where and when U.S. armed forces will deploy, but a comprehensive review of the complexities that U.S. Armed forces have worked through since the onset of OIF will gain significant understanding of the complexities and challenges faced by U.S. armed forces while conducting detention medical operations. Arguably, armies tend to base training and develop doctrine from the last war fought. As such, a comprehensive review of topics, such as types of medical conditions encountered, longevity of in-patient care, medical equipment shortfalls, chronic illnesses, rehabilitative care, pharmaceutical demands, requirements for adequate isolation wards, evacuation or patient movement requirements, pediatric and geriatric medical equipment and the process of coordinating with local medical facilities for patient transfers would assist planners in developing a medical package to conduct detention medical operations effectively and meet the requirements prescribed in U.S. law in the future.

Despite the fact that a detainee healthcare transition plan is not feasible under current conditions, a solution is possible. For a detainee healthcare transition plan to work, continuation of support from the U.S. and international community to the Iraqi government in reducing sectarian violence is needed. Bombings in crowded markets, improvised explosive devices and random shootings generate hundreds of people requiring healthcare at under resourced Iraqi medical facilities each month. In addition, kidnappings of Iraqi physicians and nurses by sectarian groups are causing a reduction in capabilities of the Iraqi healthcare system. A reduction of sectarian violence would lower

the number of patients at Iraqi medical treatment facilities and international healthcare agencies would provide more assistance throughout Iraq as the concern for the safety of agency personnel would reduce. Construction or repair of medical treatment facilities throughout Iraq would increase as interruptions of building efforts would decrease because the workers would not leave the construction site in fear of being killed. By reducing the stress on the Iraqi civilian healthcare system an increase of capabilities for the Iraqi detention healthcare system would occur. The Iraq culture places prisoners very low in society. Because of their culture, the healthcare system within detention facilities will not receive the necessary funding by Iraqi officials or consideration for employment by healthcare workers until the civilian healthcare system is capable of providing adequate medical care to Iraq citizens. As Iraqi healthcare providers are employed to conduct detention healthcare and the capabilities at Iraqi detention facilities are sustainable and in accordance with their operating policy, then a phased transition from U.S. operated to Iraqi operated detention healthcare operations can occur.

APPENDIX A

DEFINITIONS

The military, like many civilian organizations, has a distinctive terminology often misunderstood by civilians as well as military professionals. The following list clarifies key terms and allows for easy reference throughout this thesis.

Civilian Internee (CI): A CI is a person who is interned during armed conflict or occupation if he is considered a security risk or needs protection because he committed an offense against the detaining power.

Detainee: Any person captured or otherwise detained by an armed force (AR 190-8). The DAIG, states that detainee includes enemy prisoners of war (EPWs), retained persons (RP), civilian internees (CI), and other detainees (ODs).

Enemy Prisoner of War: As defined in the Geneva Convention Relative to the Treatment of Prisoners of War (GPW), 12 August 1949, an EPW is a member of an enemy armed force, a member of a militia or volunteer corps forming part of an enemy armed force. The definition continues that an EPW could be a member of a militia or volunteer corps, including an organized resistance movement that belongs to an enemy power, operating in or outside its own territory and fulfills the following conditions: the organization is commanded by a person responsible for his subordinates, the organization has a fixed, distinctive sign that is recognizable at a distance, members carry arms openly, a member of an enemy armed force who claims allegiance to a government or an authority not recognized by the detaining power or inhabitants of an unoccupied territory who spontaneously take up arms to resist invading U.S. armed forces if they carry arms openly and respect the laws and customs of war.

International Humanitarian Law: Comprises the rules which in the times of armed conflict, seek to protect people who are no longer taking part in the hostilities and restricts the methods and means in which warfare is employed.

jus ad bellum: Law on the use of force.

jus in bello (law in war): The of laws that come into effect once a war has begun with a purpose to regulate how wars are fought.

Law of Nations: The set of rules governing relations between States and other members of the international community. Synonyms include “public international law” and “international law.”

Lawful Enemy Combatant: a member of a regular armed force of a State party to a conflict; militia, volunteer corps or organized resistance movement belonging to a State party to the conflict, which are under responsible command, wear fixed distinctive sign recognizable at a distance, carry their arms openly and follow the laws of war; and members of regular armed forces who profess allegiance to a government or an authority not recognized by the detaining power are entitled to protections under the Geneva Conventions (DODD, 2006).

Levels of Care: The U.S. Army delineates five levels of care. Level I refers to first aid level of care to Advanced Trauma Life Support (ATLS). Level V is most commonly thought of as medical treatment facilities within the U.S. and medical capability of providing rehabilitative care to patients.

Level I: Immediate lifesaving measures.
Level II: Includes Level I care, provides ATLS, X-ray, laboratory and dental support.
Level III: Includes Level I, Level II, resuscitation, initial wound surgery and postoperative treatment.
Level IV: Includes Level I through Level III and provides greater postoperative care.
Level V: Includes Level I through Level IV. Level V is found in support base hospitals and includes Department of Veterans Affairs (VA) and civilian hospital beds required to meet evacuation of patients from the theater of operations.

Other Detainee (OD): A person in the custody of U.S. armed forces who has not been classified as an EPW, RP or CI is treated as an EPW until legal status is ascertained by competent authority.

Retained Persons (RP): An RP is an enemy who falls within one of the following categories: a person who is of the medical service of an enemy armed force, a chaplain attached to an enemy armed force or a member of the International Federation of Red Cross and Red Crescent Societies (IFRC) or another voluntary aid organization which is recognized and authorized by its government.

Unlawful Enemy Combatant: are enemy combatants who engage in acts against the United States or its coalition partners in violation of the laws and customs of war during an armed conflict and are not entitled to combatant immunity (DODD, 2006).

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